STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014948	A. BUILDING: _____ B. WING _____	C 06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT MANTENO	ONE VETERAN'S DRIVE MANTENO, IL 60950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 1672802/IL 85702: 340.1650 a), 340.1660 b)e) 1672860/IL 85769: 340.1650 a), 340.1660 b)e)	S 000		
S9999	Final Observations Statement of Licensure Findings 340.1650a) 340.1660b) 340.1660e) Section 340.1650 Medication Policies and Procedures a) Medication administration services are provided by a facility when medications are administered by facility staff. Facilities that provide medication administration services shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part, shall be in compliance with all applicable federal, State, and local laws, and shall be followed by the facility. These policies and procedures shall be developed with the advice of a pharmaceutical advisory committee that includes at least a pharmacist, a physician, the administrator and the director of nursing. (This is not intended to limit the facility's organization of responsibilities. Any group that includes at least these four members may approve these policies and procedures.) Section 340.1660 Administration of Medication	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014948	A. BUILDING: _____ B. WING _____	C 06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT MANTENO	ONE VETERAN'S DRIVE MANTENO, IL 60950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

b) Medications shall be administered as soon as possible after doses are prepared at the facility and shall be administered by the same person who prepared the doses for administration, except under single unit dose packaged distribution systems.
e) Medications prescribed for one resident shall not be administered to another resident.

This Requirement was not met by:

Based on observations, interviews and record reviews, the facility's nursing staff failed to give two residents' medications in a manner to ensure the right medications were given to the right resident, and according to the facility's policy and procedures for medications administration to residents/members.

This applies to two of three residents (R1 and R3), who have their medications administered to them by staff.

The findings include:

Review of R1's Face sheet showed R1 is an 89 year old who was admitted to the facility on 1/10/2014, and has diagnoses including: End Stage Renal Disease on Hemodialysis, Hypotension, Heart Failure, and Obstructive Sleep Apnea.

Review of R1's Nursing Notes showed R1 was given another resident's (R3's) medications and experienced lethargy:
"5/23/2016... 6 PM... (R1's) Medication error occurred... 5/23/2016... 9:10 PM... Member

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014948	A. BUILDING: _____ B. WING _____	C 06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT MANTENO	ONE VETERAN'S DRIVE MANTENO, IL 60950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

(R1) received another member's medications... 5/24/2016... 3:22 AM... Member administered wrong medications in error on previous shift... member (R1) is groggy. will open eyes upon request but no speaking clearly... not send to dialysis this a.m. ...5/24/2016... 1:03 PM... Member (R1) continues to be confused and lethargic. Member does not recognize staff members. No intake this shift... called for transport (to the hospital)."

R1 was transferred to a local community hospital, which showed R1's chief concerns were from medication error and multiple medical problems: "ED (Emergency Department) Note... 5/24/2016 4:21 PM... Patient (R1) arrives from ...Nursing Home, Staff reports that patient (R1) was given another resident's medications last night at 6 PM... On arrival, patient (R1) is alert to name. Appears lethargic and does not follow commands. Has Tremulous movements at times and moans out loud..."

R1's hospital's History and Physical Note, dated 5/25/2016 at 9:07 PM, showed: "R1 presents ... The nursing home reported that the patient (R1) was given incorrect medication last night and had been confused and lethargic ever since. Per EMS (Emergency Medical Services), the patient was given Baclofen (muscle relaxant) last night by Nursing Home staff... which was not on his medication list..." R1's hospital's History and Physical Note assessment of his (R1's) medical condition included: "2. Altered Mental Status From Toxic Encephalopathy (Medication)."

Review of the facility's pharmacy investigation, dated 6/06/2016, into R1's medication error showed:
"R1 was on the following Medications:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014948	A. BUILDING: _____ B. WING _____	C 06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT MANTENO	ONE VETERAN'S DRIVE MANTENO, IL 60950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

"Midodrine 5 mg, Sevelamer 2400 mg, Ferrous Sulfate 325 mg, Omeprazole 20 mg, Pravachol 40 mg, Sennalax 8.6/50 mg, Gabapentin 600 mg and Oxycodone 10 mg." But, Member (R1) Received R3's Medications Sinemet 25/100 mg (2 tablets), Baclofen 20 mg, Calcium Carbonate 10 gr, Gabapentin 600 mg, Senna S 8.6/50 mg, Simvastatin 10 mg, Tamsulosin 0.4 mg and Tramadol 50 mg. " The pharmacy identified "side effects" such as: drowsiness and decreased respiration" happening to R1 because he was given R3's medications.

Review of the facility's investigation into this incident showed: "Incident Report dated 5/23/2016... (Nurse/E8) In day room giving medications, got R1's medications ready and set them aside to give. Got R3's medications ready and grabbed the wrong ones and gave to R1." This Incident Report was not completed. It lack any documentation of corrective action taken by the facility in the area of Recommended Interventions to address this incident.

Review of the facility's policy and procedure for Medication Administration, dated 9/2010, showed: "Medication will be given in... safe manner to ensure that the right medications are given to the right member (resident)... Personnel: RN's (Registered Nurse's) AND LPN' (License Practical Nurse's) Procedure: ...7. Immediately dispense medication to member..." On 5/23/2016 for R1 this policy and procedure for administering medications to R1 and R8 was not followed, and resulted in R1 receiving the wrong medications. Also, training material given to the nursing staff, dated 6/02/2016, showed; "Only prepare one member's medication at a time, and immediately administer the medication to the member."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014948	A. BUILDING: _____ B. WING _____	C 06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT MANTENO	ONE VETERAN'S DRIVE MANTENO, IL 60950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

R1 was interviewed on 6/07/2016 at 11 AM. R1 was observed to be alert, but with periods of confusion. R1 said he could not recall what happened to him before he went to the hospital.

E8 was the nurse on duty who gave R1 the wrong medications on 5/23/2016. E8 was interviewed on 6/01/2016 at 3:30 PM. E8 described R1 as usually alert and oriented, able to feed himself, but needing total care. E8 said she had taken out R1's medication and put them in a medication cup with apple sauce to go down the hall and give it to him. E8 stated she became aware that R3 also wanted his medications and both residents (R1 and R3) were in the day room. E8 said she put R1's medication into the drawer of the medication cart and put R3's medication into another cup with apple sauce. E8 stated R1 approached her first to get his (R1's) medications, but she gave him (R1) the wrong medications, which were the evening medications for R3. E8 stated she got the two cups of medications confused because they both had pills in apple sauce. E8 said she should have given one member's his medication before going to the next members. E8 stated I was busy, working by myself, and had to give medications to 37 residents. E8 said I also had to make sure physician orders were followed up, and residents who needed treatments and/or ointments got those applied.

E4 was the nurse who sent R1 to the hospital on 5/24/2016. E4 was interviewed on 6/01/2016 at 1:06 PM. E4 said I got a report that he (R1) was given the wrong medications. E4 said she remembered R1 was confused and disorientated before going to the hospital.

The director of nursing (E2) was interviewed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014948	A. BUILDING: _____ B. WING _____	C 06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT MANTENO	ONE VETERAN'S DRIVE MANTENO, IL 60950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5 6/07/2016 at 10:30 AM. E2 said she did not do the investigation, but was reviewing the findings. E2 stated E8 pre-set up of R1's medications, and administered medications to two residents at the same time. This was not the facility's policy or procedure for administrating medications. E12 was identified as the nursing manager who conducted the investigation into R1's incident of 5/23/2016. E12 was interviewed on 6/07/2016 at 10:58 AM. E12 said her assessment of the incident was that E8 pre- pouring resident's medication resulted in the medication error occurring to R1.	S9999		